LAW ENFORCEMENT OFFICIAL'S REQUEST FOR PROTECTED HEALTH INFORMATION
CITY OF CHICAGO INDEPENDENT POLICE REVIEW AUTHORITY

TO: OUR LADY OF RESURRECTION MEDICAL CTR DATE: 27 JAN 12
(Name of institution, individual or department)

RE: [redacted]

I am a law enforcement official as defined by the Health Insurance Portability and Accountability Act (HIPAA). *See* 42 U.S.C. §1320(d) *et seq.* (2002). *See also* Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160, 162 & 164 (2002). I am employed by the City of Chicago and work for the City of Chicago's Independent Police Review Authority.

I am serving this investigative demand on you so that I may receive any and all protected health information of:

Name: [redacted]

Birth Date: [redacted]

Address: [redacted]

Social Security Number: [redacted] DATE OF INCIDENT ON OR ABOUT 04 JAN 12

In accordance with 45 C.F.R. §164.512(f), I certify that:

(1) The information sought is relevant and material to a legitimate law enforcement inquiry;

(2) This request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and

(3) De-identified information cannot be reasonably used.

(Signature of Requestor)

Roberto Soto
(Name of Requestor) (Please Print)

312-745-3609, ext 1106
(Telephone Number of Requestor)

LOG# 1057472

Attachment 25

Resurrection Health Care®

Our Lady of the Resurrection Medical Center
5645 West Addison Street
Chicago IL 60634
773-282-7000

ADMISSION RECOR

ACCOUNT NO.	ADMISSION DATE / TIME	F.C.	DATE OF BIRTH	AGE	SEX	RACE	MS	SERVICE	STATION	ROOM NO.	LOC	PAT TYPE	INT	UNIT NUMBER
12006-00317	01/06/12 9:09pm	SP	09/19/77	34Y	M	8	S	MED	ERD	-	ERRD	ERD	GD	0000616939

PATIENT

PATIENT NAME AND ADDRESS

[redacted]

Cell Phone #:

SOC-SEC-NO. [redacted]

TELEPHONE [redacted]

EMPLOYERS

PATIENT EMPLOYER
CONSTRUCTIDN

TELEPHONE

GUARANTOR

GUARANTOR NAME AND ADDRESS

[redacted]

Cell Phone #:

SOC-SEC-NO. [redacted]

TELEPHONE [redacted]

RELATION
SELF

GUARANTOR EMPLOYER
CONSTRUCTION

TELEPHONE

OCCUPATION

RELATIVE 1 [redacted]

[redacted]
OTHER
EMPLOYER TELEPHONE

Rel 1 Cell #:

RELATIVE 2

Rel 2 Cell #:

INSURANCE

INSURANCE 1
600000 SELF PAY 1
COLON,EDGARDO

INSURANCE 2

INSURANCE 3

INSURANCE 4

DIAGNOSIS / COMPLAINT	NOTICE OF PRIVACY	DATE RECEIVED	ADVANCE DIRECTIVE	DATE	STAFF ALERT
DIZZY	No				

TYPE OF ACCIDENT	NATURE OF ACCIDENT	DATE/TIME	ADM TYPE/ORIGIN	ARRIVAL MODE	DENOM
			1 / 8	CFD	CAT

MISC

ADMITTING PHYSICIAN	ADM PHY PHONE	OPT OUT	PAT. CLA	CHURCH
BORDO,DAVID J EEM	(773)794-7601	No		CATHOLIC/NO AFFILIAT

ATTENDING PHYSICIAN	ATT PHY PHONE	GROUP NAME
BORDO,DAVID J EEM	(773)794-7601	*EMERGENCY MEDICINE DLR

REFERRING PHYSICIAN

PRIMARY CARE PHYSICIAN
NO,PRIMARY CARE PHYSICIAN

PRIMARY PHY PHONE

ER PHYSICIAN
BORDO,DAVID J

A
1200600317

U
0000616939

Resurrection Health Care®

EMERGENCY DEPARTMENT RECORD

DATE / TIME OF INJURY:

LOCATION OF INJURY:

PRESENTING COMPLAINT: SOB

PMH: Ø

INITIAL NURSING ASSESSMENT:
TIME: 2120

PRESENT MEDICATIONS: ☐ (see attached list) DOSING:

[redacted]

TRANSFER TO: VIA:

CONDITION ON DISPOSITION: Good Improved Fair Poor Expired

PHYSICIAN SIGNATURE:

PRINT:

DX CODES:

TIME OUT: 2211

NURSE SIGNATURE:

[redacted]

Our Lady of the Resurrection Medical Center
Chicago, Illinois 60034

EMERGENCY DEPARTMENT
RECORD

WHITE COPY - Medical Records WHITE COPY - Patient Accounting
PINK COPY - Physician YELLOW COPY - Radiology E-1009 11/11

Our Lady of the Resurrection Medical Center
5645 West Addison Street
Chicago, Illinois 60634-5566
(773) 282-7000

NURSES' NOTES

[redacted]

34Y
Admit Dt: 01/06/12
Attending:PHYSICIAN,OLR ER
Acct#: 12006-00317 Facility: OLR
Unit#: 0000616939

[redacted]

N-1000ER 11/04

[redacted]

[redacted]

OUR LADY OF THE RESURRECTION MEDICAL CENTER
5645 W. ADDISON - CHICAGO, IL 60634
(773) 794-7610
RADIOLOGY REPORT

[redacted]

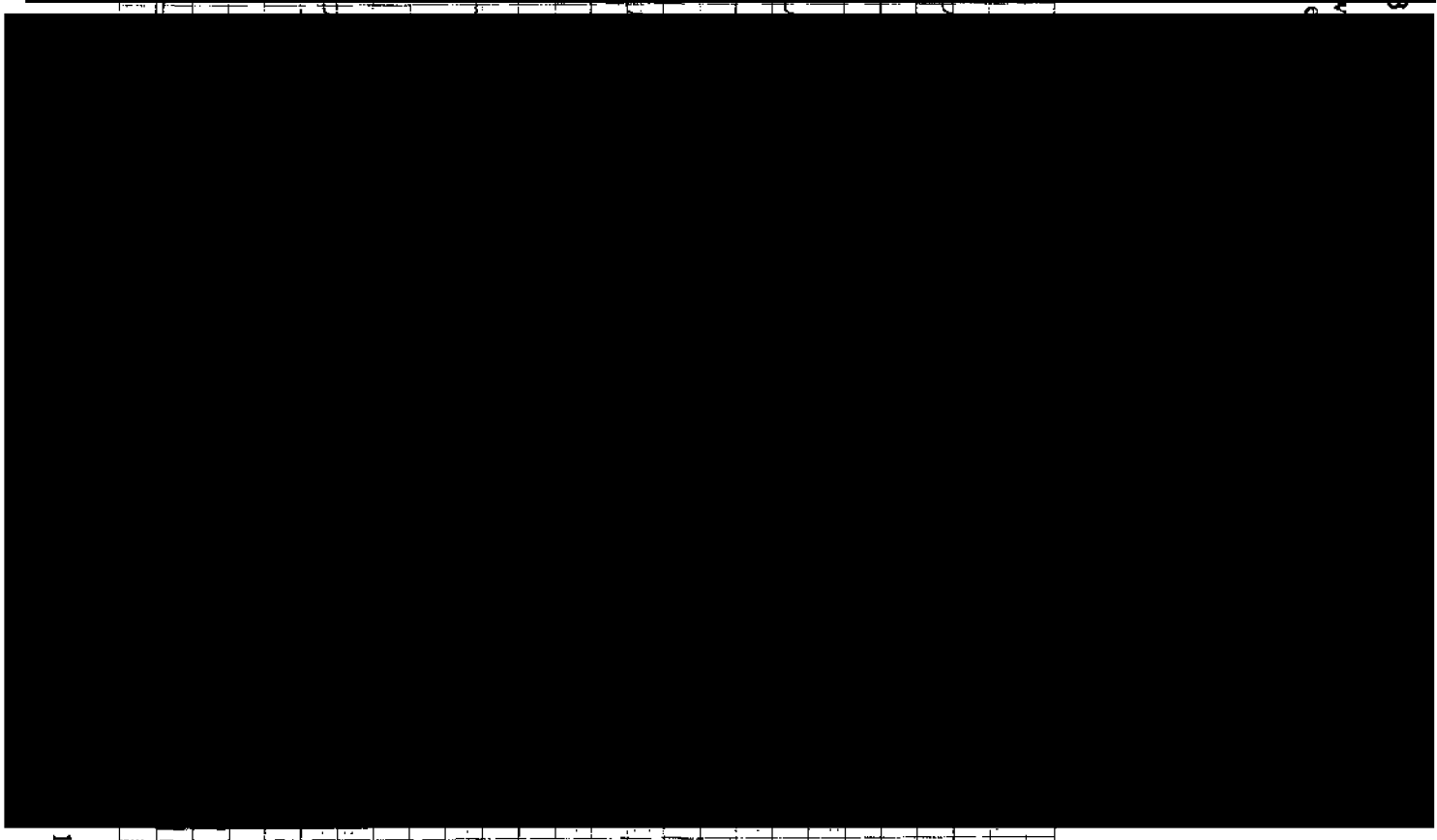
FINDINGS:

[redacted]

LOG# 1051472

Attachment 25

[redacted]



CONSENT AND AGREEMENT TO CONDITIONS OF INPATIENT TREATMENT, OUTPATIENT SURGERY, OUTPATIENT TREATMENT, BEHAVIORAL HEALTH TREATMENT, AND EMERGENCY DEPARTMENT TREATMENT

1. Consent for Care and Medical Treatment: I am known to be suffering from a condition requiring diagnosis and medical treatment, and/or cosmetic or reconstruetive procedures; therefore, I eonsent to the procedures which may be performed during this hospitalization or during outpatient surgery, outpatient services, behavioral health services, including emergency treatment or services in the Emergency Department, and which may include, but are not limited to laboratory procedures, x-ray examinations, medical or hospital services rendered to me under the general and specific instruction of my personal physician or his or her consulting physicians.

I understand that several of the Resurrection Health Care (hereinafter, "RHC") facilities have hospital residency programs. I do hereby consent to medical treatment rendered by resident physicians as may be requested by my personal physician or his or her consulting physicians. I also understand that RHC facilities employ house physicians who are available to provide for medical care from time to time when my personal physician is physically unavailable to be present to provide for my care. I hereby consent to medical treatment rendered by these physicians as may be requested by my personal physician or his or her consulting physicians.

I am aware that the practice of medicine or surgery is not an exact science, and I acknowledge that no guarantees have been made concerning the results of the proposed treatment.

I authorize my physicians to discuss my medical conditions with the agents and employees of the hospital or facility, and with his or her consulting physicians, in the furtherance of providing me health care. I waive any physician patient privilege.

2. Legal Relationship between Facility and Physician: I acknowledge, agree, and understand that any and all physicians who provide care to me during my visit to the facility are INDEPENDENT CONTRACTORS and are NOT AGENTS, SERVANTS, OR EMPLOYEES OF THE FACILITY, except and only those who have explicitly and clearly identified themselves as hospital or facility employees, either orally or by wearing of an identification badge with the name Resurrection Health Care.

I acknowledge, agree and understand that the facility is not responsible for judgment or conduct of any physician who treats or provides professional services to me, but rather each physician is an independent contractor who is not employed by the facility, except and only those who have explicitly and clearly identified themselves as hospital or facility employees, either orally or by wearing of an identification badge with the name Resurrection Health Care.

The facility has entered into agreements with physicians and independent groups of physicians to provide services to the facility. I acknowledge, agree and understand that the facility uses these independently contracted physician groups to perform specific services (such as radiologists, pathologists, anesthesiologists, neonatologists and others) for the facility and its patients. The physicians and physician groups have been permitted to use the facility for the care and treatment of their patients.

3. Physician Billing: I acknowledge, agree, and understand that each of the physician or physician groups who render professional services to me bill and collect independently for their services. I understand that their bills will be separate and apart from the facility's billing.

4. Acknowledgement: My signature below constitutes my acknowledgement and agreement that I read and understand the above, was given the opportunity to discuss this form and ask questions, that all questions were answered to my satisfaction, and I am satisfied I understand the form's contents and significance.

[redacted]

CONSENT AND AGREEMENT TO CONDITIONS OF INPATIENT TREATMENT, OUTPATIENT SURGERY, OUTPATIENT TREATMENT, BEHAVIORAL HEALTH TREATMENT, AND EMERGENCY DEPARTMENT TREATMENT

5. Consent to Release Medical Information: I hereby authorize, without further consent, this Resurrection Health Care facility and my attending physician to release minimally necessary information requested by my health care insurance company, Medicare, Medicaid, and any other third party payor or its designees to be reimbursed for hospital services on this or a related date of service. I also authorize the RHC facility, RHC and its employees to act as my/the patient's authorized representatives in obtaining Medicaid benefits.

I hereby authorize, without further consent, this Resurrection Health Care facility and my attending physician to release minimally necessary information requested by any facility or person within Resurrection Health Care for the purposes of providing health care services to me. I waive any physician patient privilege.

I hereby grant consent in the instance that my insurance company may request, and that my physicians approve, a utilization review nurse who is not an employee of the Resurrection Health Care facility to obtain minimally necessary information from me or my family members during my admissions to the Resurrection Health Care facility for the solitary purpose of obtaining insurance benefits.

The authorization may be revoked in writing at any time except to the extent that actions have been taken in reliance thereon. This authorization is valid for the period of time neeessary to process claims for payment of these services, and expires when full, accurate payment is made. I understand I will be responsible for charges incurred for my/the patient's treatment, if refusal to authorize disclosure of my/the patient's medical records, or subsequent revocation of authorization, results in a denial of payment of the insurance or third party payor claim.

I also agree that minimally neeessary information related to HIV, AIDs, drug and alcohol treatment, diagnosis and/or mental health and/or developmental disability treatment or diagnosis notes in the records of this admission may be disclosed to my health eare insurer and/or its agents, for the purpose of obtaining health care benefits. This portion of the consent is valid only for the duration of the admission. I understand that if refuse to consent, my health insurance company may deny benefits.

6. Waiver of Responsibility for Personal Property: I agree to hold this Resurrection Health Care facility harmless from any and all liability and relieve it from any and all responsibility for loss or damage of any personal property, valuables, money or any other personal belongings which I have not deposited with the Medical Center for safekeeping.

7. Assignment of Insurance Benefits: I hereby authorize and instruct my insurance company to pay any and all medical, surgical, and/or hospital benefits directly to the Resurrection Health Care facility and my attending and consulting physicians. I further hereby assign and set over to the Resurrection Health Care facility all of my rights, interests, and benefits payable under a plan or policy under which I am entitled to coverage, to the Resurrection Health Care facility concerning medical services rendered. In consideration of those hospital and medical services rendered by the Resurrection Health Care facility, I hereby assign, transfer and set over to the Resurrection Health Care faeility all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered the Resurrection Health Care facility. If my medical insurance coverage is not sufficient to satisfy the facility charges in full, I acknowledge that if the resulting balance is not be covered hy this Assignment, in the absence of an agreement between my medical insurance company and RHC, I will be fully responsible for payment of this balance according to the terms listed above, and the terms of my medical insurance coverage.

CONSENT AND AGREEMENT TO CONDITIONS OF INPATIENT TREATMENT, OUTPATIENT SURGERY, OUTPATIENT TREATMENT, BEHAVIORAL HEALTH TREATMENT, AND EMERGENCY DEPARTMENT TREATMENT

8. Financial Agreement: I agree, on my own behalf, that in consideration for services rendered or to be rendered to me/the patient, that I am hereby individually obligated to pay the account incurred at the Resurrection Health Care facility. It is specifically agreed that I will pay the amount of the full charges as appearing on the bill or statement. I also understand that all estimated balances not covered by insurance are due and payable at the time of service or as specified by the published policies of Resurrection Health Care. It is further understood that the insurance agreement is strictly between the insured and insurance company. The payment for medical services rendered is my responsibility and I agree to pay the account in full within 60 days of the discharge date. Should the account be referred to an outside firm or agency for collection, I agree to pay all collection costs, including attorney's fees and court costs.

9. Managed Care Plan Obligation: Resurrection Health Care facilities maintain a list of health care service plans/managed care plans with which they have contracted. A list of such plans is available for inspection upon request in the Business Office. I understand that it is likely that the Resurrection Health Care facility and Resurrection Health Care has no contract, express or implied, with any plan that does not appear on this list. I, the undersigned agree that I am obligated to obtain any pre-authorization that is required by my insurance or service plan, that the Resurrection Health Care facility offers this service as a courtesy only and that in doing so the Resurrection Health Care facility has made no guarantee nor has it accepted responsibility or liability for obtaining such pre-authorization nor has its efforts created a waiver of my responsibility. In the event that any services or portion of services are denied or otherwise disallowed or not paid, whether by reason or lack of such pre-authorization, ineligibility, an exclusion of the service for coverage under the insurance plan or for any other reason, I, the undersigned, specifically agree that I shall be financially obligated to pay any balance due, notwithstanding any of my insurance company's contractual prohibitions or stipulations to the contrary, to the extent such waiver is permissible under current law.

10. Medication Assistance Program: In some cases, the hospital is able to obtain reimbursement for some of your medications from companies that manufacture them. When this occurs, the cost of the medication is removed from the charges on your hospital stay. Most of these programs require your signature on the applications forms. So that you do not have to sign this application for each medication, we are requesting that you allow Pharmacy Health Solutions ("PHS") representative to sign these forms on your behalf. I appoint PHS to carry out in my name, the application forms required for PHS to obtain replacement of my medications from pharmaceutical manufacturers. This document will be in full force from the date signed.

11. Receipt of Documents: I CERTIFY THAT I HAVE RECEIVED THE FOLLOWING DOCUMENTS BY INITIALING THE BLANK: (Insert N/A as is applicable)

_____ An Important Message from Medicare/Champus _____ The Resurrection Health Care Notice of Privacy Practices

_____ Patient Rights and Responsibilities

Patient unable to sign

12. Authorization for Release Against Medical Advice: I hereby agree that if I leave the facility, or the care of my physician, without an order for discharge from my attending physician, I hereby relieve my attending physician and the Resurrection Health Care facility of all responsibility for my action.

13. Consent to Be Photographed: In connection with medical services received, I consent to any photographs ordered ordered by my physician and/or per facility protocol to be used for documentation, medical research and medical education. I waive any and all rights of ownership for such photographs. Every effort will be made to protect the patient's identity.

[redacted]

CONSENT AND AGREEMENT TO CONDITIONS OF INPATIENT TREATMENT, OUTPATIENT SURGERY, OUTPATIENT TREATMENT, BEHAVIORAL HEALTH TREATMENT, AND EMERGENCY DEPARTMENT TREATMENT

14. Use of Facsimile Transmission: I authorize the transmission of minimally necessary medical and other information, pursuant to the Resurrection Health Care system policy, via facsimile, and hold the Resurrection Health Care facility and Resurrection Health Care harmless from any and all claims that might arise from risks of accidental disclosure of medical information, which is inherent in a facsimile transmission.

15. Admission Information: For inpatients only, I have received an admission packet including educational materials for quitting smoking, and stroke.

I certify that I have read the foregoing, and either am a patient or am duly authorized by the patient's general agent to execute the above and accept the terms. Patient unable to sign Patient unable to sign

_____ 1/6/12

SIGNATURE OF PATIENT OR AUTHORIZED INDIVIDUAL DATE

RELATIONSHIP OF SIGNER TO PATIENT _____
(self, mother, father, son, daughter or explain other)

If patient is unable to sign, state reason: police custody

_____ 1/6/12

WITNESS DATE

LOG# 1051472

Attachment 25

[redacted]